



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW LICENSE APPLICATION  
BOARD OF PODIATRY

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-543-5212**, Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

**Section 1. REQUEST LICENSE TYPE/FEES (includes non-refundable application fee - see instructions)**

Check the box next to the basis by which you are applying. \*Do not select "EXAMINATION" if you have already passed the USMLE Step III Examination

PO - Podiatry by Examination	\$228.00	<b>Make check or money order payable to <u>Promissor</u></b> <b>Mail To:</b> Department of Health Health Professional Liscencing Adminstration Board of Podiatry 717 14th Street, NW Suite 600 Washington, D.C. 20005  <b>Walk-in Service</b> <b>Monday through Friday, 9 to 4 EST</b> 717 14th Street, NW Suite 600 Washington, DC 20005									
PO - Podiatry by Re-examination	\$91.00										
PO - Podiatry by Endorsement	\$228.00										
Duplicate Licenses (limit 5)	X\$26.00= \$ .00										
<b>Total Enclosed</b>	\$ .00										
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Check \$	Check #	Staff									
\$ _ _ _ .00											

**Section 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION**

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

First Name	Last Name	MI	Suffix (Jr, Sr, etc.)
Social Security Number If applicant does not provide a social security number, a sworn affidavit is required.		Date Of Birth (mm/dd/yyyy)	
Place Of Birth Provide City and State for US birthplace or Country for foreign place of birth.		Male    Female Gender Please Check the Correct Box	

**Section 3. SUPPORTING DOCUMENTS**

Please indicate the supporting documents you have included in this package **or** requested to be sent to the Board of Podiatry. Keep a photocopy of all supporting documents for your records.

**HPLA  
ONLY**

A.	Two recent passport-type photos of the applicant's face (approx. "2 X 2") with applicant's name printed on the back. Home snapshots are not acceptable.	Yes No	
B.	Proof of success completion from an educational program in the practice of podiatry at an institution accredited by the Council on Pediatric Medical Education (CPME) at the time the applicant graduated.	Yes No	
C.	Proof of passing National Exam results from the National Board of Podiatric Medical Examiners (NBPME) part 1 and part 2.	Yes No	
D.	Official transcript (with seal) from educational institution showing proof of receipt of a degree in Podiatry. Submitted in the original sealed envelope with application. Transcript may be sent directly from the institution to the Board of Podiatry, but it is preferred that it accompany the license application.	Yes No	
E.	Complete Supplemental Form listing names, addresses and signatures of three (3) professional references.	Yes No	
F.	Copies of legal documents supporting all name changes. (if applicable)	Yes No	

**Section 4. PREVIOUS NAMES**

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by:      Marriage                      Divorce                      Court Order                      Spouse Death Certificate

First Name                      MI                      Last Name                      Suffix (Jr, Sr, etc.)

Changed to current name by:      Marriage                      Divorce                      Court Order                      Spouse Death Certificate

First Name                      MI                      Last Name                      Suffix (Jr, Sr, etc.)

Changed to current name by:      Marriage                      Divorce                      Court Order                      Spouse Death Certificate

First Name                      MI                      Last Name                      Suffix (Jr, Sr, etc.)

Changed to current name by:      Marriage                      Divorce                      Court Order                      Spouse Death Certificate

First Name                      MI                      Last Name                      Suffix (Jr, Sr, etc.)

## Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

Apartment      Suite      Floor      PO Box      Number

Home Street Address 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate street number and street name)

Home Street Address 2 (If additional space is needed, use this line to indicate street number and street name)

City

State      Zip Code + 4

Home Phone Number      Home Fax Number      E-mail Address

## Section 5B. BUSINESS ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

Please note your business address will appear on the DOH website.

Company Name  
Apartment      Suite      Floor      PO Box      Number

Home Street Address 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate street number and street name)

Home Street Address 2 (If additional space is needed, use this line to indicate street number and street name)

City

State      Zip Code + 4

Business Phone Number      Business Fax Number      E-mail Address

## Section 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

Home      Business

Section 6A. PROFESSIONAL SCHOOLS ATTENDED

List all professional schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certification

Section 6B. POSTGRADUATE WORK EXPERIENCE

List all experience since graduation from professional school, in reverse chronological order, beginning with the most recent.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below*)	Full Time	Part Time

\* TYPE OF POSITION KEY  
A. Employment  
B. Private Practice  
C. Clinical Rotations  
D. Instructor  
E. Training  
F. Other (specify on separate sheet of paper)

Section 6C. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS		
List all states and jurisdictions in which you have ever held a license. Provide letters of verification from all states of licensure regardless if active, inactive, or expired.		
Jurisdiction	Date License Was First Obtained	License Number

Section 7. QUESTIONS		Applicants MUST answer all of the following questions		HPLA ONLY
Please answer all of the following questions by placing an 'X' in the appropriate boxes. If you answer 'Yes' to any of questions B through J below, you must provide full information and complete details on a separate sheet of paper and attach with this application form.				
A.	I certify that I am in compliance with the "Clean Hands Before Receiving a License or Permit Act of 1996" (DC Law 11-118, DC Code §47-2861 et seq.) and I do not owe any outstanding debt over \$100 to the District government as a result of any fine, fee, penalty, interest, or past due taxes as stipulated in that law.	Yes No		
B.	Have you ever been convicted or arrested for a crime (other than minor traffic violations) not previously reported to the Board?	Yes No		
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete section 6C of this form.)	Yes No		
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	Yes No		
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	Yes No		
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	Yes No		
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	Yes No		
H.	Has the use of drugs and/ or alcohol resulted in an impairment of your ability to practice your profession?	Yes No		
I.	(1) Have you withdrawn an application (in DC or any other state/ jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charge(s) not previously reported to this Board?	Yes No		
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	Yes No		

**Section 8. LICENSEE AFFIDAVIT**

*I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.*

\_\_\_\_\_  
**LICENSEE SIGNATURE**

\_\_\_\_\_  
**NAME (please print)**

\_\_\_\_\_  
**DATE**

<b>HPLA ONLY</b>

**To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.**